STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NVS3069AGC		GC	B. WING		04/28/2009		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, S	STATE, ZIP CODE		, ,
SUNSHIN	E RETIREMENT HON	AE .	316 LACY L LAS VEGAS		07		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	N SHOULD BE COMPLET	
Y 693 SS=F	by the Health Divisis prohibiting any crimactions or other claavailable to any parstate, or local laws.  This Statement of It a result of an annuconducted at your Licensure survey wof NRS 449.150, Portion of the facility for Group be and or persons with Category I and five census at the time resident files were files were reviewed was reviewed. The The following deficit 449.2712(2) Oxyge ability  NAC 449.2712  2. The caregivers of facility with a reside oxygen shall:  (a) Monitor the ability of the state of	conclusions of any inviton shall not be constituted investigations for relief that marty under applicable of the constituted in the conducted by the conducted by the conducted by the conducted by the conducted for elderly and don't chronic illnesses, for category II resident of the survey was eigneded and three of the conducted by a residerant who requires the conducted by a residerant who requires the conducted with the conducted and three of the conducted by a residerant who requires the conducted by the conducted by a residerant who requires the conducted by the c	estigation trued as tions, by be ederal, derated as urvey his State authority Division. The ght. Eight employee esident file ade of C. ed:  resident ential use of operate	Y 000	Acceptable  Acceptable  John Sm.  Secure the free To of organ in the G by providing A RACH Notified The Oxyger Provider FOR Pick. U calling The # 702.64 Statesery Medical E will also provide U	istrator inks arage &	
	periodically the cor	t's physician evaluate ndition of the residen	t which		Kack, for Ftank.	s a	
If deficiencies LABORATOR	es are cited, an approved Y DIRECTOR'S OR PROVI	plan of correction is requ IDER/SUPPLIER REPRESE	isite to continue NTATIVE'S SIGN	a program r	regulary TITLE Administ	u latte.	(X6) DATE J

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		` ´	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NI/C20C0ACC		A. BUILDIN B. WING		04/28/2009			
NAME OF D	DOMBED OF CURRIER	NVS3069A		DRESS CITY	STATE, ZIP CODE	V-12012003	
	ROVIDER OR SUPPLIER <b>E RETIREMENT HO</b> N	le	316 LACY		0 17 11 - 1 0 0 D C		
30143HIN		11-		AS, NV 891	07		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE	
Y 693	necessitates his us (2) Signs which persons that oxyge of the facility in whi stored; (3) Persons do where smoking is p (4) All electrical defects which may (5) All oxygen ta secured in a stand (6) The equipme is in good working (7) A portable u oxygen in the even in the facility at all to requires oxygen is (8) The equipme	e of oxygen; prohibit smoking and n is in use are poster ch oxygen is in use of not smoke in those a prohibited; equipment is inspect cause sparks. Inks kept in the facilit or to a wall; ent used to administra t of a power outage i imes when a resider present in the facility ent used to administra t of a power outage i imes when a resider present in the facility ent used to administra e facility when it is no	d in areas or is being treas ted for ty are er oxygen tion of s present at who r; and er oxygen	Y 693	B. The facility will sure that the def will Not occur by the Rack available Time. The Caregiver be made aware the the Oxygen Rack.  The facility wie livery week to and the Facility the Administrate or Caregiver. Inwill monitor becompliance.  C. 5/1/2009	at all will ese af	
Y 830 SS=D	Based on observate failed to secure oxywall. Three oxyger unsecured in the grand Severity: 2 Scott WAIVERS  1. The administrate	met as evidenced by ion on 4/28/09, the faygen tanks in a rack in tanks were observed arage.  ope: 3  or of a residential faction a written request	acility or to the ed	Y 830	1830  9. The Faility adm will Submit a war retain a bed rickle Resident #8 is n Health Care and Si Physical therapy. Therapiest Confirme Resident #8 is do ine the Therapy And She Bed ridden.	n Resident ()  rich Home  rich Home  re is Undergoin  Per physical  se theet  will	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION   IDENTIFICATI		IDENTIFICATION NUMBER: A. B.		A. BUILDIN	A. BUILDING  B. WING		COMPLETED  04/28/2009		
	<u> </u>	NVS3069A		DESS CITY	STATE ZIP CODE	04120	72.000		
SUNSHINE RETIREMENT HOME 316 LAC			316 LACY	ADDRESS, CITY, STATE, ZIP CODE CY LANE GAS, NV 89107					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		'FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
Y 830	permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive.  This RULE: is not met as evidenced by: Based on interview and record review on 4/28/09, the facility failed to request a bedridden waiver for 1 of 8 residents (Resident #8).		dential facility , y: on pedridden	Y 830	1830  B. Whenever Resident assessed to be a bedrithe Facility will Submit Reguest to Retain a begress dent to BHCQC we Proper Care Plan.  The Facility will moni every new admission peroper assessment of He makility.  Admitting Staff or Administrator will moni the Compliance.  c. 5/5/2009		for with		
Y 859 SS=D	449.274(5) Period resident  NAC 449.274 5. Before admission, or mo significant change resident, the facili general physical chis physician. The	cope: 1  lic Physical examinate on and each year after frequently if there is in the physical condity shall obtain the resexamination of the reservations provided than.	er is a lition of a sults of a sident by ared for	Y 859	1859  a. Residenta # 5  are with Hospital under Infinity Hospice about the physical and Schedulea feen on 5/8/2	to be	Mation		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		NVS3069A	GC	B. WING _		04/28/2009	
NAME OF PROVIDER OR SUPPLIER STREET A					STATE, ZIP CODE		
SUNSHIN	E RETIREMENT HON	NE	316 LACY LAS VEGA	LANE AS, NV 8910	)7		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (COM		
Y 859	Continued From Page 3  This RULE: is not met as evidenced by: Based on record review on 4/28/09 the facility failed to ensure 2 of 8 residents received an		facility	Y 859	9859  B. Whenever Resident is Admitted to the Facili Admission Requirements Should Be checked to see all Heressary Require Complete upon Adm		
Y 878	•	esident #5,and #7).  pe: 2  Medication / Change	order	Y 878	The Facility Admin	is traled itily months	
SS=D			a scribed by hange in		the Admitting Person the Administrator re For Compliance.  e. 5/8/2009  Y878  9. Resident #1 Procare Physician No.	eonnel/stappa vie monitar	
	Based on record re 4/28/09, the facility residents received (Resident #1). Do	met as evidenced by eview and interview of failed to ensure 1 of medications as president references.	on f 8 scribed t available		about the medical Refusal.  Physician order Discontinue the mander Hated at Carried Recided # 1 made 1 see attachment #	calcon red to requient	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DATE

STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS3069AGC 04/28/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 LACY LANE SUNSHINE RETIREMENT HOME LAS VEGAS, NV 89107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) Y 878 Continued From Page 4 Y 878 B. Whenever Resident week Severity: 2 Scope: 1 Refuse medication, caredwer In charge for medication Y 885 449.2742(9) Medication / Destruction Y 885 SS=E NAC 449,2742 In Order to Info 9. If the medication of a resident is discontinued, Physician the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the caregiver to bocume, any changes Whitizing the caregiver's Nates. medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall be deemed to be an acceptable method of c. 4/29/09 destruction of medication. Y885 The medicalin Destruction This RULE: is not met as evidenced by: Based on observation and interview on 4/28/09,

the facility failed to destroy medications after they were discontinued, had expired or after a resident had been transferred.

Severity: 2 Scope: 2

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Y 908 449.2746(2)(a)-(f) PRN Medication Record SS=D

> NAC 449.2746 2. A caregiver who administers medication to a resident as needed shall record the following information concerning the administration of the

(See attachment # 3 Y 908

and witness ky

Dia Continued

will

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING NVS3069AGC 04/28/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 LACY LANE SUNSHINE RETIREMENT HOME LAS VEGAS, NV 89107 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE **TAG** TAG **DEFICIENCY**) Continued From Page 5 Y 908 Y 908 4885 medication: its correction every month (a) The reason for the administration. (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident 's physician. c. 4/30/09 ( see allachned 4908 a. The Administrator This RULE: is not met as evidenced by: Based on record review on 4/28/09, the facility Caregiver assigned failed to ensure the medication record was manage medication wil complete for 1 of 8 residents receiving as needed (PRN) medications (Resident #2) the PRN Medication RECORD PRH MAGS Order I See attackment # Severity: 2 Scope: 1 Y 936 Y 936 449.2749(1)(e) Resident file b. The Fairly will use SS=F allachment # 4 NAC 449.2749 1. A separate file must be maintained for each mediculion resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical RECAP is being Clone information and any other information related to the resident, including without limitation: Administrator to monitor for (e) Evidence of compliance with the provisions of compliance. chapter 441A of NRS and the regulations c. 4/29/2009 adopted pursuant thereto.

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		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS3069A	GC	B. WING_	<del></del>	04/28/2009	
NAME OF P	ROVIDER OR SUPPLIER		į.		STATE, ZIP CODE		
SUNSHIN	E RETIREMENT HON		<u> </u>	LANE AS, NV 891			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETE	
Y 936	Based on record re failed to ensure 1 c NAC 441A.380 reg #7) which affected	met as evidenced by eview on 4/28/09, the of 8 residents complications to the complication of the complication of the complication of the complication of the complex of th	facility ed with	Y 936	1936  9. Resident # 7  Scheduled for  PPD Text. For &  Step 21 was &  on 5/8/2009 o  Step will ke for  Ordered.  B. Whenever Res  Admitted in H  Care Facility K  TB Text Prior &  will be Submit  In Compliance  NAC 441A. 380  Policy will Ir  TB Text Prior  with out TB Text  with out TB Text  with out TB Text  with be pendin  to prevent re oir  Focility await &  To monitor for Ca  Administrator w  responsible . (See of  C. 5/21/2009	a Steps of the 1st of the Residential Leguired in admission to Admission of In arder very Comonels of the private of the priva	

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